VERMONT
Department of Vermont Health Access
NOB 1South, 280 State Drive
Waterbury, Vermont 05671-1010

~INFLIXIMAB~

Prior Authorization Request Form

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Change Healthcare. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare Helpdesk at 1-844-679-5363.

Submit request via: Fax: 1-844-679-5366

Prescribing physician:

Name: _____
Phone#: _____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:

Name: _____
Medicaid ID#:_____
Date of Birth: _____ Sex: _____
Pharmacy Name_____
Pharmacy Phone: _____Pharmacy Fax: _____

The following MUST be completed for MEDICAL BENEFIT requests:

- HCPCS J-code or other code: _____
- Administering Provider/Facility: Name_____ NPI#_____Medicaid ID#_____

Please **check box** if this drug is being provided under the DVHA's 340B Drug program and requires the **TB modifier** ☐

Patient Diagnosis:

☐ Ankylosing Spondylitis ☐ Crohn's Disease ☐ Plaque Psoriasis ☐ Psoriatic Arthritis ☐ Rheumatoid Arthritis ☐ Ulcerative Colitis

Preferred Medications:

☐ Remicade® (infliximab) ☐ Renflexis® (infliximab-abda)

Non-preferred Medications (clinical documentation must be submitted detailing why the patient cannot use Remicade or Renflexis):

☐ Avsola® (infliximab-axxq) ☐ Inflectra® (infliximab-dyyb)

Patient weight_____(kg)

Induction Dosing and Frequency:

☐ 5mg/kg at weeks 0, 2, and 6, then every 8 weeks (Ankylosing Spondylitis, Plaque Psoriasis, Psoriatic Arthritis, Crohn's Disease and Ulcerative Colitis)

☐ 3mg/kg at weeks 0, 2, and 6, then every 8 weeks (Rheumatoid Arthritis)

☐ Other: _____

Maintenance Dosing and Frequency:

☐ _____mg every 8 weeks (up to 10mg/kg for Rheumatoid Arthritis, 5mg/kg for all other diagnoses)

☐ Other: _____

List previous medications tried and failed for this condition:

Name of medication	Reason for failure	Date (s) attempted
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please explain why self-injectables (if indicated but not trialed) cannot be trialed?

_____

Prescriber comments: _____

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and/or recoupment.

Prescriber Signature: _____ **Date of request:** _____